

"Mueller Company" 1/11/2023

To Whom it may concern i was terminated because I didnt want to give the company my blood. But then they said they terminated for points. Then i Received a letter in the mail saying that it was a involuntary or ~~an~~ reduction in hours.

Dreyer Moore

Terminated for these Reason

FILED

JAN 18 2023

Clerk, U. S. District Court  
Eastern District of Tennessee  
At Chattanooga

## **To All Mueller Employees**

The test you are about to take is NOT the COVID-19 Test

This is a screening to check your system for anti-bodies

Your body produces anti-bodies to defend against various infections such as the common cold, the flu, or various other reasons such as COVID-19

Anti-bodies may exist in your body long after you have successfully fought any number of various infections

### **A Negative Test Result for Anti-Bodies**

A negative test result does not mean you are free of the COVID-19 virus

A negative test result only indicates that you have no trace of anti-bodies active in your system

A negative test result is a good indicator that your body is not fighting off the COVID-19 virus or any other infection

If you were exposed to the COVID-19 virus less than 14 days ago you may show negative anti-body test result because your body possibly has not begun to fight the virus

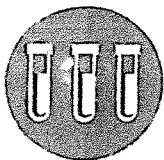
### **A Positive Test Result for Anti-Bodies**

A positive test result does not mean you have the COVID-19 virus

A positive test result only demonstrates that you have anti-bodies active in your system that are fighting or have fought a past infection (cold, flu, COVID-19, or other)

If you test Positive, you will be sent to another location for the official COVID-19 lab test

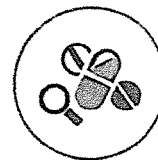
\*\*\* the above statements are not considered official medical advice or guidance, but general information used by the company to conduct employee screening\*\*\*



**LABORATORY SERVICE CENTER -  
PHYSICIAN SERVICES**

2650 Executive Park, Suite 5 \* Cleveland, TN 37312

Phone: (423) 479-9679 | Fax: (423) 559-9046



***COVID-19 Rapid Antibody Results***

Employee ID: 3012769

Name: (Last) Moorer (First) Gregory

Date of Birth: 24-May-1968

Company Representative: **CHRISTY**

Antibody Markers Read within 20 min <sup>UE</sup> Yes X No         

<u>Antibody</u>	<u>NEGATIVE</u>	<u>POSITIVE</u>
<u>IgG</u>		
<u>IgM</u>		

**THE COVID-19 RAPID QUICK TEST HAS LIMITATIONS AS A DIAGNOSTIC TOOL. THIS DEVICE CAN ONLY DETECT ANTIBODY MARKERS, GENERALLY AFTER 5-7 DAYS FROM CONTRACTING COVID-19. A NEGATIVE RESULT DOES NOT MEAN YOU ARE NOT CURRENTLY INFECTED. YOU MAY STILL BE A RISK TO OTHERS & MAY DEVELOP MORE SEVERE SYMPTOMS. A POSITIVE RESULT MAY ALSO INDICATE A PREVIOUS INFECTION.**

**CONSENT & ACKNOWLEDGMENT SECTION**

EMPLOYEE SIGNATURE: \_\_\_\_\_

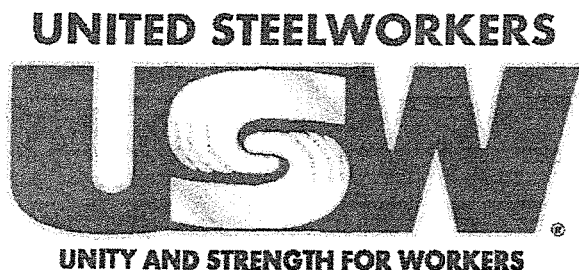
DATE: \_\_\_\_\_

Laboratory Service Center's (THE COMPANY) COVID-19 Rapid Test Device falls within the scope of the FDA guidance document issued on March 16, 2020 (<https://www.fda.gov/media/135659/download>) which allows such tests to be sold into the US market for professional use only at point-of-care sites. The COVID-19 IgG and IgM Rapid Test is designed to detect the antibodies that develop in the body following exposure to Coronavirus. Symptoms of COVID-19 are expected to appear 1-14 days following viral exposure. The company is required by law to provide the Purchaser with the following reporting requirements:

- \*The Rapid Test Device has not been reviewed by the FDA.
- \*Negative results do not rule out SARS-CoV-2 infection, particularly in those who have been in contact with the virus.
- \*Results from antibody testing should not be used as the sole basis to diagnose or exclude SARS-CoV-2 infection or to inform infection status.
- \*Positive results may be due to past or present infection with non-SARS-CoV-2 coronavirus strains, such as coronavirus HKU1, NL63, OC43, or 229E.
- \*Follow-up testing with a molecular PCR lab test should be strongly considered to rule out a current infection.

The purchaser acknowledges that no test is 100% specific and 100% sensitive so while the purchaser may receive an initial negative result, the purchaser may still produce more acute symptoms in a matter of hours or days. Purchaser further acknowledges that a false negative result may be due to a lack of detection of the viral load and/or lack of accumulation of antibodies in its early stages. In either or both cases, the purchaser acknowledges a personal responsibility to seek immediate care if symptoms worsen with a medical professional or with the emergency department of a local hospital. If a rapid positive were to occur, the patient/donor is strongly encouraged to complete a confirmatory lab-based specimen collection for quantitative analysis. If the patient/donor is unable or unwilling to do so, we will ask the respective donor/patient to comply and participate in completion of a CDC persons under investigation (PUI) form.

I consent to the company's (Physician Services Drug & Alcohol Testing) use and disclosure of my protected health information, where necessary; to facilitate the coordination of care, meet all conditions of hire, comply with the terms of your current employment, and/or respond to specific legal or government requests. I may request a copy of the company's HIPAA Notice of Privacy Practices at any time. I acknowledge that this authorization may be revoked in writing, at any time, except to the extent that the company has already relied on this authorization.



## District 9

**Daniel Flippo**  
District Director

**Mark Cochran**  
Assistant to the Director

**Wesley Thompson**  
Sub-District Director

May 19, 2020

Certified Mail No.: 7019 2970 0002 2201 9911  
Return Receipt Requested

Greg Moorer  
P. O. Box 22523  
Chattanooga, TN 37422

Dear Greg Moorer:

I write in regards to the grievance concerning the termination of your employment from Mueller Company. The Union has now fully exhausted the grievance procedure, and the grievance has unfortunately been denied.

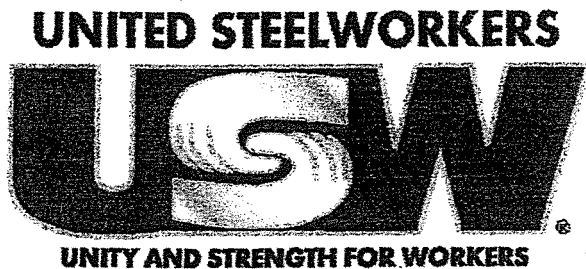
The Union has made a determination that the grievance lacks sufficient merit for the Union to prevail in an arbitration hearing. Therefore, the Union will not proceed to arbitrate this grievance, and will withdraw the grievance.

Sincerely,

Wesley Thompson  
Sub-District Director

WT:dc

cc: Clifford Rucker, President, Local 03115  
File



I Never sign  
any paper's for a  
Grievance. I had  
one meeting after  
Terminating. that  
was it. this is the  
reason I contact  
the HRC.

*Megay Moore*  
9/27/2020

### District 9

Daniel Flippo  
District Director

Mark Cochran  
Assistant to the Director

Wesley Thompson  
Sub-District Director

May 19, 2020

Certified Mail No.: 7019 2970 0002 2201 9911  
Return Receipt Requested

Greg Mooror  
P. O. Box 22523  
Chattanooga, TN 37422

Dear Greg Mooror:

I write in regards to the grievance concerning the termination of your employment from Mueller Company. The Union has now fully exhausted the grievance procedure, and the grievance has unfortunately been denied.

The Union has made a determination that the grievance lacks sufficient merit for the Union to prevail in an arbitration hearing. Therefore, the Union will not proceed to arbitrate this grievance, and will withdraw the grievance.

Sincerely,

Wesley Thompson  
Sub-District Director

WT:dc

cc: Clifford Rucker, President, Local 03115  
File

at the first and  
only meeting. I  
told this man  
about this paper.

*Megay Moore*  
9/27/2020

2<sup>nd</sup> letter

Payflex Systems USA, Inc.  
Mueller Group, LLC  
BENEFITS BILLING DEPARTMENT  
P.O. BOX 953374  
ST. LOUIS, MO 63195-3374  
(888) 678-7835 (TTY:711)

June 23, 2021

Gregory Moorner  
PO Box 22523  
Chattanooga, TN 37421

Dear Gregory Moorner,

We have received your REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL form, seeking approval to receive the COBRA premium subsidy available through the American Rescue Plan Act (ARP).

Upon review, we have determined you are ineligible for the subsidy under ARP for the following reason(s):

To be eligible for the subsidy, you must be able to answer each statement with a YES.

Based on the above reason(s), your request to be treated as an Assistance Eligible Individual has been denied. If you have mistakenly answered the statement incorrectly please resubmit an updated form.

For group health plans sponsored by private-sector employers, guidance and other information is available on the DOL web site at <https://www.dol.gov/cobra-subsidy>.

If you have any questions, please contact our COBRA Department at (888) 678-7835 (TTY:711) Monday through Friday 7:00 am to 7:00 pm CT.

Sincerely,

PayFlex Systems USA, INC



*2nd letter front & Back*

**COBRA Continuation Coverage Election Form (for individuals not currently on COBRA)**

**Instructions:** To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days from the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan, unless you are entitled to additional time under a federal policy or program. For example, you may be entitled to more time because of a national emergency. However, if you fail to elect COBRA continuation coverage and the premium assistance 60 days from the date of this notice, you may be ineligible for the premium assistance and the additional COBRA election period under the ARP.

Send completed Election Form to: PayFlex Systems USA, Inc. Benefits Billing Dept. P.O. Box 953374 St. Louis, MO 63195-3374

This Election Form must be completed and accompanied by the "Request for Treatment as an Assistance Eligible Individual" form and returned by mail to the above address or via email to: [PFX-ARPAMemberMail@aetna.com](mailto:PFX-ARPAMemberMail@aetna.com)

If mailed, it must be post-marked no later than 60 days from the date of this notice.

If you don't submit a completed Election Form by the due date shown above, you may lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date. Read the important information about your rights included in the pages after the Election Form.

If you do not have your list of eligible coverages visit our website at [www.payflex.com](http://www.payflex.com). You may also email us at: [PFX-ARPAMemberMail@aetna.com](mailto:PFX-ARPAMemberMail@aetna.com) or call (888) 678-7835.

Participant ID: 6273162

**Please Indicate your Effective date of COBRA Coverage:** \_\_\_\_\_  
(Can only be April 1, 2021 or later)

I (We) elect COBRA continuation coverage in the **Mueller Group, LLC.** (the Plan) listed below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
------	---------------	--------------------------	---------------------------

a. \_\_\_\_\_

Coverage option elected: \_\_\_\_\_

b. \_\_\_\_\_

Coverage option elected: \_\_\_\_\_

c. \_\_\_\_\_

Coverage options elected: \_\_\_\_\_

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address Telephone number

To apply for ARP Premium Assistance, complete this form and return it to PayFlex. If you have not yet elected COBRA continuation coverage, you may send this form along with your Election Form. If you do not complete this form and return it within 60 days of receipt, you may be unable to receive the premium assistance.

If you are already enrolled in COBRA, you may send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to:

**PayFlex Systems USA Inc., Benefits Billing Department P.O. Box 953374 St. Louis, MO 63195-3374**

You may also want to read the important information about the rules for premium assistance included in the "Summary of the COBRA Premium Assistance Provisions Under the American Rescue Plan Act of 2021."

Mueller Group, LLC.  
1200 ABERNATHY  
ROAD, NE  
SUITE 1200  
ATLANTA, GA 30328

## REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Participant ID:  
6273162

### PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.

1. The qualifying event was a loss of employment that was involuntary or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming premium assistance).	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance).	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please Indicate your Effective date of ARPA Subsidy:  
(Can only be April 1, 2021 or later)

#### IMPORTANT NOTES:

Already Enrolled in COBRA - You can either mail or Email this form "Request for Treatment as an Assistance Eligible individual" to the address noted above or via email to: [PFX-ARPAMemberMail@aetna.com](mailto:PFX-ARPAMemberMail@aetna.com)

If you are currently in your 60 day election period you can either mail or email this form to: [PFX-ARPAMemberMail@aetna.com](mailto:PFX-ARPAMemberMail@aetna.com)

Not Enrolled in COBRA - Mail in the COBRA Continuation Coverage Election Form along with this form "Request for Treatment as an Assistance Eligible Individual" to the address noted above.



2nd letter

487

I make an election to exercise my right to ARP premium assistance and attest that I meet the requirements for treatment as an Assistance Eligible Individual. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_ Relationship to employee → \_\_\_\_\_

**FOR EMPLOYER OR PLAN USE ONLY**

This request is: ☐ Approved ☐ Denied Specify reason in #3 below and return a copy of this form to the applicant.

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

- |  |                          |
|--|--------------------------|
| 1. Loss of employment was voluntary.                   | <input type="checkbox"/> |
| 2. Individual did not experience a reduction in hours. | <input type="checkbox"/> |
| 3. Individual did not elect COBRA coverage.            | <input type="checkbox"/> |
| 4. Other (please explain)                              | <input type="checkbox"/> |

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

→ \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_

Telephone number → \_\_\_\_\_ E-mail address → \_\_\_\_\_

**For Further Assistance, you may contact the Department of Labor's Employee Benefits Administration at 1-866-444-3272, or online at <https://www.askebsa.dol.gov/WebIntake>.**

**DEPENDENT INFORMATION** (Parent or guardian should sign for minor children.)

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. \_\_\_\_\_

- |   |  |
|---|--|
| 1. I elected (or am electing) COBRA continuation coverage.                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. I am NOT eligible for other group health plan coverage.                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I am NOT eligible for Medicare.  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. The qualifying event was an involuntary termination or a reduction in hours. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_ Relationship to employee → \_\_\_\_\_

Silver Right's, HIPAA Vilation's

5/4/20

My Name is Gregory moorer.

I Started working at Mueller Company.  
On or about 7/20/2013. right to the point of  
My Vilation's form the Company. on April 13, 2020.  
mueller Company sent out a text to all there  
employee. that they were having a mandatory  
Blood test done. on the job in there parking  
lot. on the date of April 14, 15 of 2020. I  
did not lean about the blood test until  
the 13 of April. because the last day of work  
was wed. the 8 April 2020. here are some  
of my Vilation's the company have done  
and I feel have Vilated My Silver Right's,  
HIPAA Right's. making me come down to the  
Company. to do a blood test. Told me I couldn't  
go to my Dr. to have the test done. I had to go  
to there Dr. and told me they were going to  
sale my Results. Fired me under the Dr. Care.  
let me work 2 1/2 days then Fired me. then  
did not pay me the day's I worked. I have  
nothing but problem's after the first year's  
working for this company. they have try twice  
trying to get my medical Records.

Cell

(423) 838-8762

Over

This Company terminated me  
because <sup>it did not</sup> sign this paper to sell  
my medical Records

Dujoy Moore  
PO Box 22523  
Chatt, TN 37422

C 423<sup>1</sup>838-8762



PayFlex Systems USA, Inc. for  
Mueller Group, LLC.  
BENEFIT BILLING DEPARTMENT  
P.O. BOX 953374  
ST. LOUIS, MO 63195-3374  
(800) 359-3921 (TTY:711)

May 27, 2021

GREGORY MOORER and Family, if applicable  
P.O. BOX 22523  
CHATTANOOGA, TN 37421

If they didn't  
do anything wrong  
why did they offer  
Insurance

Dear GREGORY MOORER, and Family, if applicable

**This notice has important information about your new rights related to continued health care coverage in the Mueller Group, LLC. (the Plan).**

The American Rescue Plan Act of 2021 (ARP) provides temporary premium assistance for COBRA continuation coverage. Premium assistance is available to certain individuals who are eligible for COBRA continuation coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment. If you qualify for premium assistance, you do not need to pay any of the COBRA premium otherwise due to the plan for the months when you are eligible for premium assistance. This premium assistance is available from April 1, 2021 through September 30, 2021. If you choose to continue your COBRA continuation coverage beyond that date, you may have to pay the full COBRA premium amount due. However, when your premium assistance ends, you may qualify for a special enrollment period to enroll in coverage through the Health Insurance Marketplace<sup>®1</sup> (see section on "other coverage options" below).

You are receiving this notice because you experienced a qualifying event that may have been a reduction in hours or an involuntary termination of employment and you have not reached the maximum period for your COBRA continuation coverage or did not elect COBRA continuation coverage when it was first offered.

To help determine whether you can get the ARP premium assistance, you should read this notice and the attached documents carefully. In particular, review the "Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan of 2021" with details regarding eligibility, restrictions, and obligations and the "Request for Treatment as an Assistance Eligible Individual."

**If you believe you meet the criteria for the premium assistance, complete the "Request for Treatment as an Assistance Eligible Individual" form (provided in the Summary of COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021 as an attachment to this notice) and return it with your completed Election Form enclosed, or separately, if you are currently enrolled in COBRA continuation coverage.**

<sup>1</sup> Health Insurance Marketplace<sup>®</sup> is a registered service mark of the U.S. Department of Health & Human Services.

**Section 1: "I do not have COBRA continuation coverage":**

- A. If I now elect COBRA continuation coverage when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin on April 1, 2021 or the date indicated on your COBRA Qualifying Event election notice if after April 1<sup>st</sup> and can last until the end date indicated on your Qualifying Event election notice, previously received.

COBRA continuation coverage may end before your COBRA end date described above in certain circumstances, including for failure to pay premiums, for fraud, or if you become covered by another group health plan.

Note, due to the COVID-19 National Emergency, the Department of Labor, the Department of the Treasury, and the Internal Revenue Service issued a Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak ("Joint Notice").<sup>2</sup> This notice provided relief for certain actions related to employee benefit plans required or permitted under Title I of ERISA and the Code, including the 60-day initial election period for COBRA continuation coverage. The Department of Labor's Employee Benefits Security Administration (EBSA) provided further guidance on this relief in EBSA Disaster Relief Notice 2021-01.<sup>3</sup> The extended deadline relief provided in the Joint Notice and Notice 2021-01 does not apply, however, to the 60-day election period related to COBRA premium assistance under the ARP. Potential Assistance Eligible Individuals therefore must elect COBRA continuation coverage within 60 days of the date of this notice or forfeit your right to elect COBRA continuation coverage with premium assistance.

However, a potential Assistance Eligible Individual has the choice of electing COBRA continuation coverage beginning April 1, 2021 or after (or beginning prospectively from the date of your qualifying event if your qualifying event is after April 1, 2021), or electing COBRA continuation coverage commencing from an earlier qualifying event if you are eligible to make that election, including under the extended time frames provided by the Joint Notice. The election period for COBRA continuation coverage with premium assistance does not cut off an individual's preexisting right to elect COBRA continuation coverage, including under the extended timeframes provided by the Joint Notice and EBSA Disaster Relief Notice 2021-01.

- B. Can I now extend the length of COBRA continuation coverage?

If you now elect COBRA continuation coverage, you may be able to extend the length of COBRA continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify **PayFlex Systems USA, Inc.** of a disability or a second qualifying event within a certain time period to extend the period of COBRA continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of COBRA continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf>

- C. How much does COBRA continuation coverage now cost?

COBRA continuation coverage costs will be provided via your COBRA Billing statement once we receive your "Request for Treatment as an Assistance Eligible Individual" and "Election form". The ARP reduces the COBRA premium to zero for certain individuals. Premium assistance is available to certain individuals who are eligible for COBRA continuation coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment. If you qualify for premium assistance, you need not pay any of the COBRA premium otherwise due to the plan. This premium assistance is available from April 1, 2021 through September 30, 2021. If you choose to continue your COBRA continuation coverage beyond that date, you may have to pay the full amount due. See the attached "Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan of 2021" for more details, restrictions, and obligations as well as the form to complete to establish eligibility.

<sup>2</sup> 85 FR 26351 (May 4, 2020).

<sup>3</sup> Available at <https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01.pdf>.

1st letter  
Gregory Moore

4873

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for premium assistance under the ARP.

Mail this form to: PayFlex Systems USA Inc., Benefits Billing Dept. PO Box 953374 St. Louis, MO 63195-3374

Mueller Group, LLC.  
1200 ABERNATHY  
ROAD, NE  
SUITE 1200  
ATLANTA, GA 30328

### Participant Notification

Participant ID:  
6273162

### PERSONAL INFORMATION

\*Name and mailing address

\*Telephone number

\*E-mail address (optional)

### PREMIUM ASSISTANCE INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan.  
If any dependents are also eligible, include their names below.

Insert date you became eligible \_\_\_\_\_



I am eligible for Medicare.

Insert date you became eligible \_\_\_\_\_



### IMPORTANT

If you fail to notify your plan when you become eligible for other group health plan coverage or Medicare AND continue to receive COBRA premium assistance you may be subject to a penalty of \$250 dollars (or if the failure is fraudulent, the greater of \$250 or 110% of the amount of the premium assistance provided after termination of eligibility). You won't be subject to the penalty if your failure to notify the plan is due to reasonable cause and not due to willful neglect.

Eligibility for other coverage is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

\_\_\_\_\_  
\_\_\_\_\_



1st letter Gregory Moore

If you qualify as an "Assistance Eligible Individual" this monthly premium cost will be zero from April 1, 2021 through September 30, 2021 and you do not have to send any payment with the election form.

**Section II:** I am currently enrolled in COBRA:

**A. How do I apply for premium assistance under the ARP program?**

If you believe you meet the criteria for premium assistance complete the enclosed Request for Treatment as an Assistance Eligible form and return it to the address indicated on the form.

**B. Will I have to pay any premium if I am eligible for ARP premium assistance?**

If you qualify for premium assistance you need not pay any of the COBRA premium for your current benefits and dependents that meet the ARP eligibility requirements from April 1, 2021- September 30, 2021. You may be required to pay a premium for your current benefits and dependents that are not ARP eligible and you will receive billing notices if applicable.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. There may be other coverage options for you and your family through the Health Insurance Marketplace®, Medicare, or other group health plan coverage options (such as a spouse's plan) through a special enrollment period. Additionally, you may apply for and, if eligible, enroll in Medicaid at any time. If you are not eligible for premium assistance under the ARP, some of these options may cost less than COBRA continuation coverage. If you are eligible for other group health plan coverage, such as through a new employer's plan or a spouse's plan (not including excepted benefits, a qualified small employer health reimbursement arrangement, or a health flexible spending arrangement), or if you are eligible for Medicare, you are not eligible for ARP premium assistance. However, if you have individual market health insurance coverage, like a plan through the Marketplace, or if you have Medicaid, you may be eligible for ARP premium assistance if you elect COBRA continuation coverage. Note, however, that you will not be eligible for a premium tax credit, or advance payments of the premium tax credit, for your Marketplace coverage for months that you are enrolled in COBRA continuation coverage and you may not be eligible for months during which you remain an employee but are eligible for COBRA continuation coverage with premium assistance because of a reduction of hours. If you're eligible for Medicare, consider signing up during its special enrollment period to avoid a coverage gap when your COBRA coverage ends and a late enrollment penalty.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA, because the new coverage may impose a new deductible. Also, keep in mind that if you elect COBRA continuation coverage with premium assistance, then you may qualify for a special enrollment period to enroll in Marketplace coverage when your premium assistance ends. You may use the special enrollment period to enroll in Marketplace coverage with a tax credit if you end your COBRA continuation coverage when your premium assistance ends and you are otherwise eligible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option until the next available open enrollment period.

**For more information**

This notice doesn't fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, contact:

**PayFlex Systems USA, Inc. Benefits Billing Dept. P.O. Box 953374 St. Louis, MO 63195-3374 or call (888) 678-7835.**

If you want a copy of your summary plan description, please contact your former employer.

4866

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's EBSA website at <https://www.dol.gov/agencies/ebsa>, go to [www.askebsa.dol.gov](http://www.askebsa.dol.gov), or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace®, and to locate an assister in your area who you can talk to about the different options, visit [www.HealthCare.gov](http://www.HealthCare.gov).

#### **Keep Your Plan Informed of Address Changes**

To protect your and your family's rights, still keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also still keep a copy of any notices you send to the Plan Administrator.

UNITED STATES OF AMERICA  
NATIONAL LABOR RELATIONS BOARD  
CHARGE AGAINST LABOR ORGANIZATION  
OR ITS AGENTS

DO NOT WRITE IN THIS SPACE	
Case	Date Filed

INSTRUCTIONS: File an original with NLRB Regional Director for the region in which the alleged unfair labor practice occurred or is occurring.

1. LABOR ORGANIZATION OR ITS AGENTS AGAINST WHICH CHARGE IS BROUGHT			
a. Name United Steel Workers		b. Union Representative to contact President of the Union Clifford Rucker	
c. Address (Street, city, state, and ZIP code) 60 Boulevard of the Allies Pittsburgh PA 15222		d. Tel. No. —	e. Cell No. (423) 320-1357
		f. Fax No. —	
		g. e-mail —	
h. The above-named labor organization has engaged in and is engaging in unfair labor practices within the meaning of section 8(b) and (list subsections) of the National Labor Relations Act, and these unfair labor practices are practices affecting commerce within the meaning of the Act, or these unfair labor practices affecting commerce within the meaning of the Act and the Postal Reorganization Act.			
2. Basis of the Charge (set forth a clear and concise statement of the facts constituting the alleged unfair labor practices) Terminate for not giving my blood to the Company, on the job site. And the Union never file a Grievance after Terminating me.			
3. Name of Employer Mueller Company 1401 mueller ave. Chattanooga, TN 37406		4a. Tel. No. (423) 698-8811	b. Cell No. —
		c. Fax No. —	
		d. e-mail —	
5. Location of plant involved (street, city, state and ZIP code) 1401 mueller ave Chattanooga, TN 37406		6. Employer representative to contact President of Union Clifford Rucker (423) 320-1357	
7. Type of establishment (factory, mine, wholesaler, etc.) foundry	8. Identify principal product or service Grinder	9. Number of workers employed 400 plus	
10. Full name of party filing charge Gregory Moorer			
11. Address of party filing charge (street, city, state and ZIP code) P.O. Box 22523 Chattanooga, TN 37422		11a. Tel. No. —	b. Cell No. (423) 838-4762
		c. Fax No. —	
		d. e-mail moorer-Gregory@yahoo.com	
12. DECLARATION I declare that I have read the above charge and that the statements are true to the best of my knowledge and belief.  Gregory Moorer (signature of representative or person making charge)  Gregory Moorer (Print/type name and title or office, if any)		Tel. No. —	
		Cell No. (423) 838-8762	
		Fax No. —	
		e-mail moorer-Gregory@yahoo.com	
Address P.O. Box 22523 Chatt, TN 37422		Date 9-27-20	

WILLFUL FALSE STATEMENTS ON THIS CHARGE CAN BE PUNISHED BY FINE AND IMPRISONMENT (U.S. CODE, TITLE 18, SECTION 1001)  
PRIVACY ACT STATEMENT

Solicitation of the information on this form is authorized by the National Labor Relations Act (NLRA), 29 U.S.C. § 151 et seq. The principal use of the information is to assist the National Labor Relations Board (NLRB) in processing unfair labor practice and related proceedings or litigation. The routine uses for the information are fully set forth in the Federal Register, 71 Fed. Reg. 74942-43 (Dec. 13, 2006). The NLRB will further explain these uses upon request. Disclosure of this information to the NLRB is voluntary; however, failure to supply the information may cause the NLRB to decline to invoke its processes.



Type Report: Merit \_\_\_\_\_ Reprimand X Today's Date 4/22/2020

Employee Name: Greg Moorer Clock# 3012769

Rule Violated 2 Reason Attendance Policy

Company Statement:

5/21/2019	6A	0.5
5/29/2019	6A	0.5
6/10/2019	6D	0.5
7/1/2019	6A	0.5
7/22/2019	1A	1
10/22/2019		minus one point for Perfect Attendance
11/4/2019	6A	0.5
11/19/2019	6A	0.5
12/2/2019	6A	0.5
12/16/2019	6A	0.5
3/10/2020	6A	0.5
4/1/2020	6A	0.5
4/7/2020	6A	0.5
4/15/2020	1A	1
4/16/2020	1A	1

Total Points: 7.5 points

Employee Response:

Committee man  
refused to sign  
the 2 warning  
which they try  
to give me on  
the 5th day.  
Clifford Kuecker  
said I could not  
file a grievance.  
9/27/2019  
Heaven

Action Taken Final Warning Date of Action 4/22/2020

[Signature]  
Supervisor

Refused  
Employee

Refused  
Committeeman

4-22-20  
Date Signed



STATE OF TENNESSEE  
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT ■ DIVISION OF EMPLOY

**SEPARATION NOTICE**

1. Employee's Name: Gregory Moorer 2. SSN                       
First Middle Initial Last  
3. Last Employed: From: 07/22/13 to 04/27/20 Occupation: Casting Finisher  
(mm/dd/yy) (mm/dd/yy)  
4. Where was work performed? Mueller Co. 1401 Mueller Ave. Chattanooga, TN. 37406

5. Reason for Separation: ☐ Lack of Work ☒ Discharge ☐ Quit

If lack of work, indicate if layoff is ☐ Permanent ☐ Temporary - Recall Date                       
(mm/dd/yy)

If temporary, report any vacation pay that will be paid. Week Ending Date                      Amount \$                       
(mm/dd/yy)

If layoff is indefinite vacation pay should not be reported.

6. Employee received: ☐ Wages in Lieu of Notice ☐ Severance Pay

In the amount of \$                      for period from                      to                       
(mm/dd/yy) (mm/dd/yy)

If other than lack of work, explain the circumstances of this separation:

Absenteeism

Employer's Name:

Address where additional information may be obtained:

Mueller Co.  
1401 Mueller Ave.  
Chattanooga, TN. 37406

Employer's Telephone Number:

(423) 698-8811

Employer's E-Mail Address:

Employer's Account Number: 004-220

*(Number shown on State Quarterly Wage Report (LB-0851) and  
Premium Report (LB-0456))*

I certify that the above worker has been separated from work and the information furnished hereon is true and correct. **This report has been handed to or mailed to the worker.**

Signature of Official or Representative of the Employer  
who has first-hand knowledge of the separation

Title of Person Signing

Date Completed and Released to  
Employee

Human Resource Asst.

04/28/20  
(mm/dd/yy)

**NOTICE TO EMPLOYER**

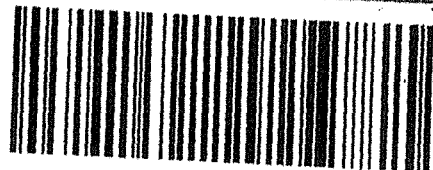
Within 24 hours of the time of separation, you are required by Rule 0800-09-01 of the Tennessee Employment Security Law to provide the employee with this document, properly executed, giving the reasons for separation. If you subsequently receive a time sensitive request for separation information for the same information please give complete information in your response.

**NOTICE TO EMPLOYEE**

IF YOU ARE FILING A CLAIM FOR UNEMPLOYMENT INSURANCE BENEFITS BY TELEPHONE OR INTERNET YOU MAY BE INSTRUCTED TO MAIL OR FAX THE SEPARATION NOTICE TO THE TENNESSEE CLAIMS CENTER. IF YOU ARE FILING A CLAIM FOR UNEMPLOYMENT INSURANCE BENEFITS IN-PERSON PLEASE TAKE THIS NOTICE TO THE LABOR AND WORKFORCE DEVELOPMENT OFFICE.



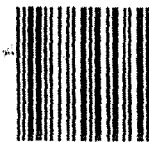
District 9  
460 Distribution Parkway  
Collierville, TN 38017



7019 2970 0002 2201 9911



1000



37422

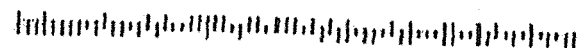
U.S. POSTAGE PAID  
FCM LETTER  
MEMPHIS, TN  
38134  
MAY 19, 20  
AMOUNT

**\$6.95**

R2305K136833-02

Greg Moorer  
PO Box 22523  
Chattanooga, TN 37422

37422-252323





## Discrimination at Mueller Co.

My name is Gregory moorer  
I have been working for Mueller  
Company for seven years start  
date 7-20-2013 till 4-27-2020.

My first day at Mueller Company  
in orientation me and another  
white employee where the only  
one in orientation besides  
ms. Yronne Whitlard ask me  
how did you pass the test to  
get this job. She never ask the  
white employee the same thing.

I did not respond because I  
needed the job. Moving on to the  
next time discrimination took  
place is when working for Dewayne  
Campbell in the cleaning room  
calling you boy putting his hands  
in my face. I reported this to  
personnel. When we got up to  
personnel Chris was the Human  
Resource person. He ask me did  
I like working at Mueller Company.  
that was all that was said in  
that meeting they did nothing

to the Supervisor which was  
Dewayne Campbell. These are the  
latest events that happened three  
months ago. Which makes it  
around sometime in March. we (around 3/2020)  
have another supervisor name  
Roger Ray who was over second  
shift cleaning room he refers  
calling his employees Sam Bo.  
Moving on to the latest event  
on or about some time in  
February while sitting in the cleaning  
room office Joe Burchess son ~~the~~  
who is a Supervisor at Mueller  
Company stated to Richard Hall  
he did know I was in the room  
meaning Gregory Moore he said  
when I was at my Aunt house  
in East Lake this six year old  
Nigger boy. After he said that  
I said what did you say then  
he said nothing. So another employee  
was in the office too his name  
is Richard Hall. ~~he~~ said I said  
Richard did you here that Richard  
said yes Greg I'm sorry man.

In closing this letter the Supervisor  
are calling people meaning African  
American boys on a daily basis.

Sincerely,

Gregory Moore

6-4-20

Gregory Moore

838-8762

(334) 4384-3964

SilverRight's, HIPAA Vilation's

5/4/20

My Name is Gregory Moorer.

I Started working at mueller Company.  
On or about 7/20/2013. right to the point of  
my Vilation's form the Company. on April 13, 2020.  
mueller Company sent out a text to all there  
employee. that they were having a mandatory  
Blood test done. On the job in there parking  
lot. On the date of April 14, 15 of 2020. I  
did not learn about the blood test until  
the 18 of April. because the last day of work  
was Wed. the 8 April 2020. here are some  
Of my Vilation's the company have done  
and I feel have V. lated My Silver Right's,  
HIPAA Right's. making me come down to the  
Company. to do a blood test. Told me I couldn't  
go to my Dr. to have the test done. I had to go  
to there Dr. and told me they were going to  
sale my Results. Fired me under the Dr. Care.  
let me work 2 1/2 days then Fired me. then  
did not pay me the day's I worked. I have  
nothing but problem's after the first year's  
working for this company, they have try twice  
trying to get my medical Records.

Over

Cell  
(423) 838-8762





Mueller Co., LLC  
1401 Mueller Avenue  
Chattanooga, TN 37406

phone: 423-495-1273  
muellercompany.com

**CERTIFIED MAIL**

April 27, 2020

Greg Moorer  
1903 E. 27<sup>th</sup> Street  
Chattanooga, TN 37407

Dear Mr. Moorer:

As you are aware, management conducted an investigation in reference to your violation of the Chattanooga Attendance Policy. During the investigation you failed to provide us with supporting documentation to account for your absences, as such you are hereby terminated effective April 27, 2020.

Sincerely,

*Tracy McMahon*

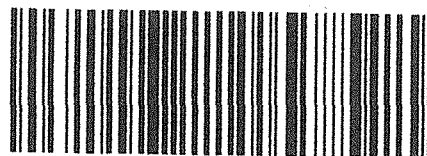
Tracy McMahon  
Human Resources Manager

cc: Eric Birdwell  
Fred Bork  
Yvonne Weller  
Clifford Rucker

**MUELLER**

Mueller Water Products  
1401 Mueller Avenue  
Chattanooga, TN 37406

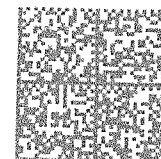
**CERTIFIED MAIL**



7018 2290 0002 2593 1182

CHATTANOOGA  
TN 373  
28 APR 20  
PM 1 L

FIRST-CLASS



**US POSTAGE**  
02 1P  
0002106873 APR 27 2020  
MAILED FROM ZIP CODE 37406  
**\$ 006.90<sup>0</sup>**

Greg moover  
1903 E. 27th street  
Chattanooga, TN 37407





STATE OF TENNESSEE  
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT ■ DIVISION OF EMPLOY  
**SEPARATION NOTICE**

1. Employee's Name: Gregory Moorer 2. SSN                       
First Middle Initial Last

3. Last Employed: From: 07/22/13 to 04/27/20 Occupation: Casting Finisher  
(mm/dd/yy) (mm/dd/yy)

4. Where was work performed? Mueller Co. 1401 Mueller Ave. Chattanooga, TN. 37406

5. Reason for Separation: ☐ Lack of Work ☒ Discharge ☐ Quit

If lack of work, indicate if layoff is ☐ Permanent ☐ Temporary - Recall Date                       
(mm/dd/yy)

If temporary, report any vacation pay that will be paid. Week Ending Date                      Amount \$                       
(mm/dd/yy)

If layoff is indefinite vacation pay should not be reported.

6. Employee received: ☐ Wages in Lieu of Notice ☐ Severance Pay

In the amount of \$                      for period from                      to                       
(mm/dd/yy) (mm/dd/yy)

If other than lack of work, explain the circumstances of this separation:

Absenteeism

Employer's Name:

Address where additional information may be obtained:

Mueller Co.  
1401 Mueller Ave.  
Chattanooga, TN. 37406

Employer's Telephone Number:

(423) 698-8811

Employer's E-Mail Address:

Employer's Account Number: 004-220

*(Number shown on State Quarterly Wage Report (LB-0851) and  
Premium Report (LB-0456))*

I certify that the above worker has been separated from work and the information furnished hereon is true and correct. This report has been handed to or mailed to the worker.

Signature of Official or Representative of the Employer  
who has first-hand knowledge of the separation

Title of Person Signing

Date Completed and Released to  
Employee

Human Resource Asst.

04/28/20  
(mm/dd/yy)

**NOTICE TO EMPLOYER**

Within 24 hours of the time of separation, you are required by Rule 0800-09-01 of the Tennessee Employment Security Law to provide the employee with this document, properly executed, giving the reasons for separation. If you subsequently receive a time sensitive request for separation information for the same information please give complete information in your response.

**NOTICE TO EMPLOYEE**

IF YOU ARE FILING A CLAIM FOR UNEMPLOYMENT INSURANCE BENEFITS BY TELEPHONE OR INTERNET YOU MAY BE INSTRUCTED TO MAIL OR FAX THE SEPARATION NOTICE TO THE TENNESSEE CLAIMS CENTER. IF YOU ARE FILING A CLAIM FOR UNEMPLOYMENT INSURANCE BENEFITS IN PERSON PLEASE TAKE THIS NOTICE TO THE CLAIMS CENTER.



# Mueller Co.

Type Report: Merit \_\_\_\_\_ Reprimand X Today's Date 4/23/2020

Employee Name: Greg Moorer Clock# 3012769

Rule Violated 2 Reason Attendance Policy

## Company Statement:

5/21/2019	6A	0.5
5/29/2019	6A	0.5
6/10/2019	6D	0.5
7/1/2019	6A	0.5
7/27/2019	1A	1
10/22/2019		minus one point for Perfect Attendance
11/4/2019	6A	0.5
11/13/2019	6A	0.5
12/2/2019	6A	0.5
12/16/2019	6A	0.5
3/10/2020	6A	0.5
4/1/2020	6A	0.5
4/7/2020	6A	0.5
4/15/2020	1A	1
4/16/2020	1A	1
4/20/2020	1A	1
4/21/2020	1A	1

Still under  
doctor's care  
and still received  
points on  
4/20 - 4/21

Total Points: 9.5 points

## Employee Response:

Action Taken Suspension Pending Discharge Investigation Investigation Date of Action 4/25/2020

Fred Bork  
Supervisor

RTS  
Employee

Chris  
Committeeman

4-25-20  
Date Signed





Type Report: Merit \_\_\_\_\_ Reprimand X Today's Date 4/22/2020

Employee Name: Greg Moorer Clock# 3012769

Rule Violated 2 Reason Attendance Policy

Company Statement:

5/21/2019	6A	0.5	in the same Day	
5/29/2019	6A	0.5		
6/10/2019	6D	0.5		
7/1/2019	6A	0.5		
7/22/2019	1A	1		
10/22/2019		minus one point for Perfect Attendance		
11/4/2019	6A	0.5		
11/19/2019	6A	0.5		
12/2/2019	6A	0.5		
12/16/2019	6A	0.5		
3/10/2020	6A	0.5		
4/1/2020	6A	0.5		
4/7/2020	6A	0.5		
4/14/2020	1A	1		
4/15/2020	1A	1		

Total Points: 7.5 points

Employee Response:

h Action Taken Final Warning Date of Action 4/22/2020

[Signature]  
Supervisor

[Signature]  
Committeeman  
Marchant Robinson

Refused  
Employee

4/22/20  
Date Signed



Type Report: Merit \_\_\_\_\_ Reprimand X Today's Date 4/22/2020

Employee Name: Greg Moorer Clock# 3012769

Rule Violated 2 Reason Attendance Policy

Company Statement:

5/21/2019	6A	0.5	I refused to sign this write up After been wrote up for the same Thing.	
5/29/2019	6A	0.5		
6/10/2019	6D	0.5		
7/1/2019	6A	0.5		
7/22/2019	1A	1		
10/22/2019		minus one point for Perfect Attendance		
11/4/2019	6A	0.5		
11/19/2019	6A	0.5		
12/2/2019	6A	0.5		
12/16/2019	6A	0.5		
3/10/2020	6A	0.5		
4/1/2020	6A	0.5		
4/7/2020	6A	0.5		
4/15/2020	1A	1		
4/16/2020	1A	1		

Total Points: 7.5 points

Employee Response:

Action Taken Final Warning Date of Action 4/22/2020

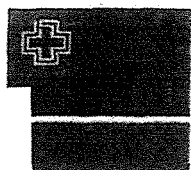
[Signature]  
Supervisor

Refused  
Employee

Refused  
Committeeman

4-22-20  
Date Signed

Doctor's Excuse



**PHYSICIANS  
CARE**

*An Affiliate of Urgent Team*

4747 Hwy 58

Chattanooga

TN 37416-2231

Phone: (423) 834-9400

Fax: (423) 834-9401

[www.urgentteam.com](http://www.urgentteam.com)

### **Excuse for Absenteeism**

Date of Service: 4/17/2020

Patient Name: Gregory Moorer

The above patient was seen in our clinic today for an injury/illness and was under the care of

Kirk, Larry, PAC

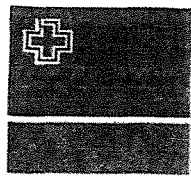
This patient may return on the date and with any restrictions noted here:

14d quarantine pending test results for Covid 19, we have been getting these test results back in 3-4 days so if negative will give results to patient and can return to work at that time.

Please feel free to call our office with any questions!

A handwritten signature in black ink, appearing to be 'L. Kirk', with 'PAC' written below it.





**PHYSICIANS  
CARE**

*An Affiliate of Urgent Team*

Phone: 4238349400

Fax: 4238349401

[www.urgentteam.com](http://www.urgentteam.com)

### **Excuse for Absenteeism**

Date of Service: 4/21/2020

Patient Name: Gregory Moorer

The above patient was seen in our clinic today for an injury/illness and was under the care of

Terriest Haire NP

This patient may return on the date and with any restrictions noted here:

04/22/2020

Please feel free to call our office with any questions!